114. 2 CMR 6.00 STANDARD PAYMENTS TO NURSING FACILITIES

(a) General. Except as provided below, Providers must file required Cost Reports for the calendar year by 5:00 P.M. of April 1 of the following calendar year. If April 1 falls on a weekend or holiday, the reports are due by 5:00 P.M. of the following business day.

1. Change of Ownership. The transferor must file Cost Reports within 60 days after a Change of Ownership. The Division will notify the Division of Medical Assistance if required reports are not timely filed for appropriate action by that agency.
2. New Facilities and Facilities with Major Additions. New Facilities and facilities with Major Additions that become operational during the Rate Year must file year end Cost Reports within 60 days after the close of the first two calendar years of operation.
3. Hospital-Based Nursing Facilities. Hospital-Based Nursing Facilities must file Cost Reports no later than 90 days after the close of the hospital's fiscal year.
4. Termination of Provider Contract. If a Provider contract between the Provider and the Division of Medical Assistance is terminated, the Provider must file Cost Reports covering the current reporting period or portion thereof covered by the contract within 60 days of termination.
5. Appointment of a Resident Protector Receiver. If a receiver is appointed pursuant to M.G.L. c. 111, s. 72N, the Provider must file Cost Reports for the current reporting period or portion thereof, within 60 of the receiver's appointment.

(b) Extension of Filing Date. The Director of the ACE Group may grant a request for an extension of the filing due date for a maximum of 45 calendar days. In order to receive an extension, the Provider must:

1. submit the request itself, and not by agent or other representative;
2. demonstrate exceptional circumstances which prevent the Provider from meeting the deadline; and
3. file the request no later than 30 calendar days before the due date.

(6) Incomplete Submissions. If the Cost Reports are incomplete, the Division will notify the Provider in writing within 120 days of receipt. The Division will specify the additional information which the Provider must submit to complete the Cost Reports. The Provider must file the required information within 25 days of the date of notification or by April 1 of the year the Cost Reports are filed, whichever is later. If the Division fails to notify the Provider within the 120-day period, the Cost Reports will be considered complete and will be deemed to be filed on the date of receipt.

(7) Audits. The Division and the Division of Medical Assistance may conduct Desk Audits or Field Audits to ensure accuracy and consistency in reporting. Providers must submit additional data and documentation relating to the cost report, the operations of the Provider and any Related Party as requested during a Desk or Field Audit even if the Division has accepted the Provider's Cost Reports.

(8) Penalties for Late Filing of Cost Reports.

(a) If a Provider does not file the required Cost Reports by the due date, the Division will reduce the Provider's rates for current services by 5% on the day following the date the submission is due and 5% for each month of non-compliance thereafter. The reduction accrues cumulatively such that the rate reduction equals 5% for the first month late, 10% for the second month late and so on. The rate will be restored effective on the date the Cost Report is filed.

(b) If a Provider has not filed its Cost Report by six months after the due date, the Division will notify the Provider thirty days in advance that it may terminate the Provider's rates for current services. The Division will rescind termination on the date that the Provider files the required report.

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6.07 Special Provisions.

(1) Rate Filings. The Division will file certified rates of payment for Nursing Facilities with the Secretary of the Commonwealth.

(2) Appeals. A Provider may file an appeal at the Division of Administrative Law Appeals of any rate established pursuant to 114.2 CMR 6.00 within 30 calendar days after the Division files the rate with the State Secretary The Division may amend a rate or request additional information from the Provider even if the Provider has filed a pending appeal .

(3) Information Bulletins. The Division may issue administrative information bulletins to clarify provisions of 114.2 CMR 6.00 which shall be deemed to be incorporated in the provisions of 114.2 CMR 6.00. The Division will file the bulletins with the State Secretary, distribute copies to Providers, and make the bulletins accessible to the public at the Division's offices during regular business hours.

(4) Severability. The provisions of 114.2 CMR 6.00 are severable. If any provision of 114.2 CMR 6.00 or the application of any provision of 114.2 CMR 6.00 is held invalid or unconstitutional, such provision will not be construed to affect the validity or constitutionality of any other provision of 114.2 CMR 6.00 or the application of any other provision.

REGULATORY AUTHORITY

114.2 CMR 6.00: M.G.L. c. 118G.

Any provider who violates the provisions of this section by failing to provide care to a medical assistance recipient residing in its facility shall be subject to a fine of one thousand dollars for each violation.

As a method of providing medical assistance to recipients, the division is authorized to contract with any fiscal agent, institution, health insurer, health maintenance organization, health plan, management service or consultant firm consistent with the requirements of 42 CFR Part 434 to administer all or part of the services and benefits available under this chapter; or, to establish a health maintenance organization; provided, that said health maintenance organization shall be operated in accordance with applicable federal and state law.

118E:13. **Rates; approval; review.**

Section 13. The commissioner shall review, and approve or disapprove, any change in Title XIX rates or Title XIX rate methodology proposed by the division of health care finance and policy established by chapter one hundred and eighteen G, which shall be called the "division" only for purposes of this section. The commissioner shall review such proposed rate changes for consistency with agency policy and federal requirements, and within the level of funding available as authorized by the general appropriation act prior to the certification of such rates by the division; provided, that the commissioner shall not disapprove a rate increase solely based on the availability of funding if the federal health care financing administration provides written documentation that federal reimbursement would be denied as a result of said disapproval and said documentation is submitted to the house and senate committees on ways and means. The commissioner shall, when disapproving a rate increase, submit the reasons for disapproval to the division together with any recommendations for changes. Such disapproval and recommendations, if any, shall be submitted after the commissioner is notified that the division intends to propose a rate increase for any class of provider under Title XIX; but in no event later than the date of the public hearing held by the division regarding such rate change; provided, that no rates shall take effect without the approval of the commissioner. The division and the commissioner shall provide documentation on the reasons for increases in any class of approved rates that exceed the medical component of the consumer price index to the house and senate committees on ways and means. The division shall supply the commissioner with all statistical information necessary to carry out his duties under this section. Notwithstanding the foregoing, the commissioner shall not review, approve, or disapprove any such rate set pursuant to chapter twenty-three of the acts of nineteen hundred and eighty-eight. If projected payments from rates necessary to conform to applicable requirements of Title XIX are estimated by the commissioner to exceed the amount of funding appropriated for such purpose in the general appropriation act in any fiscal year, the division and the commissioner

shall jointly prepare and submit to the Governor a proposal for the minimum amount of supplemental funding necessary to satisfy the requirements of the under Title XIX state plan.

118E:13A. Non-acute hospitals; rates and terms of payment.

Section 13A. For hospital fiscal years beginning on or after October first, nineteen hundred and ninety-seven, rates and terms of payment established by the division with non-acute hospitals for services rendered to patients entitled to medical assistance under this chapter shall be established by contract between the division and such hospitals, unless otherwise required by law. Prior to said October first, for those non-acute hospitals whose rates and terms of payment have not been established by contract with the division, said rates and terms of payment shall be based on the system of reimbursement in effect immediately prior to the effective date of this section. This section shall not be construed preventing said division and a non-acute hospital from agreeing to such a contract prior to such date. Any medical necessity and administratively necessary determinations the division may establish for non-acute hospitals shall be based on the screening criteria and procedures applied by peer review organizations as are duly authorized under the Social Security Act.

For any hospital fiscal year subsequent to nineteen hundred and ninety-eight, the division of medical assistance may elect, solely at its discretion, that public payor-dependent non-acute hospitals shall be subject to the provisions of the preceding paragraph; provided, that reimbursement so established by said section shall include an administratively necessary day adjustment for any patient that a public payor-dependent non-acute hospital is unable to place in a more appropriate facility based on said screening criteria and procedures; provided further that the terms of payment for any such patient shall reflect the reasonable costs of any such hospital in providing care to recipients of medical care and assistance; and provided further, that reimbursement so established shall reflect the reasonable costs of treating a disproportionate share of public payor patients.

118E:14. Nursing home negotiated rate contracts.

Section 14. Pursuant to the second paragraph of section twelve, the division shall enter into negotiated rate contracts with nursing homes that recognize the acquisition cost, or portion thereof which exceeds the allowable basis under relevant regulations of the rate setting commission, as the allowable basis of fixed assets where there has been a change of ownership effective on or after January first, nineteen hundred and eighty-seven, provided that:

cannot be adequately assured pending the full hearing and decision on the matter.

As used in this section "emergency" shall mean a situation or condition which presents imminent danger of death or serious physical harm to patients, including but not limited to imminent or actual abandonment of an occupied facility, and excluding a crisis due solely to a natural disaster beyond the control of the licensee where the licensee is taking appropriate remedial steps. An organized labor activity conducted for union recognition or as a tactic in contract negotiations shall not, of itself, constitute an emergency. Voluntary withdrawal from participation as a provider of services under the medical care and assistance program, established under chapter one hundred and eighteen E, or under the program of health insurance for the aged and disabled established under Title XVIII of the Social Security Act (P.L. -89-97) where such withdrawal was not occasioned by the denial of certification to the facility, shall not, of itself, constitute an emergency.

111:72N. Action to appoint receiver; hearing; list of persons; purpose of receivership; stay of actions.

Section 72N. The department or the attorney general may bring an action in the superior court department of the trial court requesting the appointment of a receiver to operate a facility. Before the department brings such an action, a nursing home administrator designated by the commissioner shall be informed that the department intends to bring such an action and shall be informed of the reasons for the decision to bring such an action. Said administrator shall be duly licensed according to the provisions of section one hundred and eleven of chapter one hundred and twelve of the General Laws and shall have at least five years experience as a nursing home administrator. Said administrator may submit his recommendations concerning the facility proposed for receivership within two business days after receiving the above information. After said two-day period, the department, in its sole discretion may bring an action in the superior court department described in this section. A resident or guardian of a resident may petition the department or the attorney general to seek a receivership under this section. If the department or attorney general denies such petition or fails to commence action within five days, the party bringing the petition may bring suit in the superior court department for the appointment of a receiver or other appropriate relief under this section. Upon filing of this suit, a resident or guardian shall serve a copy of the complaint on the department. Prior to any hearing for the appointment of a receiver, the department shall file, and the court shall consider, an affidavit made under oath describing the results of any investigation conducted by the department, including a statement of any findings with respect to the resident's petition and the reasons for not filing an action pursuant to this section, and shall append thereto the two most recent reports of

deficiencies in that facility. Nothing in this chapter shall be construed as abrogating or superseding any common law or statutory right of any person to bring an action requesting appointment of a receiver to operate a facility.

The department may, in its sole discretion, in addition to or in lieu of bringing an action hereunder, assist a licensee in seeking a rate adjustment or other relief from the rate setting commission.

The court shall issue a short order of notice and, where an emergency is alleged, set the matter for hearing within five days after filing of the action. In all other cases, a hearing shall be set within two weeks. A receiver shall be appointed immediately, on an ex parte basis, if it appears by verified complaint or by affidavit that there are grounds for the appointment of a receiver and that immediate appointment is necessary to prevent harm to the residents.

The court may appoint as a receiver any person appearing on a list established for the purpose by the commissioner and the secretary of elder affairs after consultation with representatives of the nursing home industry. Persons appearing on said list shall have experience in the delivery of health care services, and, if feasible, shall have experience with the operation of long term care facilities.

The purpose of a receivership created under this section shall be to safeguard the health, safety and continuity of care to residents and to protect them from the adverse health effects and increased risk of death caused by abrupt or unsuitable transfer. A receiver appointed hereunder shall not take any actions or assume any responsibilities inconsistent with this purpose.

No person shall impede the operation of a receivership created under this section. There shall be an automatic stay for a sixty-day period subsequent to the appointment of a receiver, of any action that would interfere with the functioning of the facility, including but not limited to cancellation of insurance policies executed by the licensee, termination of utility services, attachments or set-offs of resident trust funds and working capital accounts, and repossession of equipment used in the facility.

111:72O. Authority of receiver; duties; closure of facility; repairs; financial assistance.

Section 72O. When a receiver is appointed, the licensee shall be divested of possession and control of the facility in favor of the receiver. With the approval of the court, the receiver shall have authority to remedy violations of federal and state law and regulations governing the operation of the facility; to hire, direct, manage and discharge any consultant or employees, including the administrator of the facility; to receive and expend in a reasonable and prudent manner the revenues of